

File

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1. TRANSMITTAL NUMBER: <u>00-003</u></td> <td style="width: 50%;">2. STATE: Vermont</td> </tr> <tr> <td colspan="2">3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</td> </tr> <tr> <td colspan="2">4. PROPOSED EFFECTIVE DATE January 1, 2000</td> </tr> </table>	1. TRANSMITTAL NUMBER: <u>00-003</u>	2. STATE: Vermont	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)		4. PROPOSED EFFECTIVE DATE January 1, 2000	
1. TRANSMITTAL NUMBER: <u>00-003</u>	2. STATE: Vermont							
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)								
4. PROPOSED EFFECTIVE DATE January 1, 2000								
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES								
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT								
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)								
6. FEDERAL STATUTE/REGULATION CITATION: Social Security Act § 1924, 1902(a); 42 CFR 435.1005, 435.1006	7. FEDERAL BUDGET IMPACT: a. FFY <u>2000</u> \$ <u>- 0 -</u> b. FFY _____ \$ _____							
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  See Attached.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  See Attached							
10. SUBJECT OF AMENDMENT:  Update Medicaid eligibility standards								
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <div style="float: right; text-align: right;"> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <i>Forken C. Hays Secretary of Administration for the Governor</i> </div>								
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>M. Jane Kitchel</i>	16. RETURN TO:  Marybeth McCaffrey, J.D. Health Care Policy Analyst DSW - PED 103 South Main Street Waterbury, VT 05671							
13. TYPED NAME: Secretary, Agency of Human Services	17. DATE RECEIVED: <u>3/31/2000</u>							
14. TITLE:	18. DATE APPROVED: <u>June 6, 2001</u>							
15. DATE SUBMITTED: March 31, 2000	FOR REGIONAL OFFICE USE ONLY							
19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>1-1-2000</u>	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Ronald Preston</i>							
21. TYPED NAME: Ronald Preston	22. TITLE: Director's Regional Administrator							
23. REMARKS: <i>Attachment 2.6-A Supplement #6 withdrawn at State's request</i>								

Revision: HCFA-PM-97-2  
December 1997

ATTACHMENT 2.6-A  
Page 5a  
OMB No.:0938-0673

State: Vermont

Condition	Condition or Requirement
<u>X</u>	Amount for maintenance of home is: \$ <u>427.25</u> .
<u>      </u>	Amount for maintenance of home is the actual maintenance costs not to exceed \$ <u>      </u> .
<u>      </u>	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
<u>X</u>	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

TN No. 00-03  
Supersedes  
TN No. 99-16

Approval Date 06-26-01 Effective Date 01/1/00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: Vermont

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

X Applicable to all groups.

   Applicable to all groups except those specified below.

Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for _1_ month	(3) Amount by which Column (2) exceeds limits specified in 42 CFR § 435.1007 <sup>1/</sup>	(4) Net income level for persons living in rural areas for _1_ month	(5) Amount by which Column (2) exceeds limits specified in 42 CFR § 435.1007 <sup>1/</sup>
	[X] Urban only [ ] Urban & rural			
1	\$766	\$0	\$708	\$0
2	\$766	\$0	\$708	\$0
3	\$908	\$0	\$858	\$0
4	\$1,025	\$0	\$966	\$0
5	\$1,150	\$0	\$1,091	\$0
6	\$1,225	\$0	\$1,166	\$0
7	\$1,366	\$0	\$1,308	\$0
8	\$1,483	\$0	\$1,425	\$0
9	\$1,591	\$0	\$1,533	\$0
10	\$1,700	\$0	\$1,641	\$0
For each additional person add:	\$100	\$0	\$100	\$0

<sup>1/</sup> The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

Revision: HCFA-AT-85-3  
State: Vermont

Withdrawn By State 5/16/01  
Supplement #6  
To ATTACHMENT 2.6-A

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Payment Level (Monthly)*	
	Federal	State	One person with gross income $\leq$ \$1,500 per month	Couple with gross income $\leq$ \$3,000.00 per month
Independent Living Outside Chittenden County	X		\$569.66	877.28
Independent Living Chittenden County	X		\$569.66	\$877.28
Another's Household	X		\$379.72	\$559.85
Licensed Residential Care Level III (Limited Nursing Care)		X	\$772.87	\$1,358.54
Licensed Residential Care Level III (Assistive Community Care)	X		\$559.50	\$863.50
Licensed Residential Care Care Level IV	X		\$730.69	\$1,317.89
Custodial Care Family Home	X		\$608.38	\$1,094.02
Long-Term Care (Medicaid Payment)	X		\$47.25	\$94.50

\*Vermont applies federal SSI program eligibility criteria, income disregards, and resource limitations.

42 CFR 435.1005  
42 CFR 435.1006

Withdrawn By State 5/16/01

TN: 00-03  
Supersedes  
TN: 99-13

Approval date: \_\_\_\_\_ Effective date: 1/1/00